Upcoming FOA Strategies to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health 2013 – 2018

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Outline

- CDC focus on coordination and 4 domains
- Funding Opportunity Announcement
 - Purpose
 - Two applications
 - Outcomes
 - Logic Models
- Asthma-related Activities



CDC Direction: Coordination

- Increase cost effectiveness of programs
- Demonstrate
 improvement in areas
 we've already been
 working on categorically
- Demonstrate positive outcomes from coordinated projects

- Increase sustainability of chronic disease programs
- Increase staff leadership capacity
- Increase cross-program sharing of staff expertise, skills, and knowledge to build capacity of all staff



Chronic Disease Coordination

 Strategically aligned shared functions: epi/surveillance, communications, policy development, partner engagement, etc.

Frees up resources for additional programmatic efforts

Common set of public health functions



CDC 4 Domains

Build and strengthen state health department capacity and expertise to effectively prevent chronic disease and promote health.

Surveillance & Epidemiology

Health System Interventions

Environmental Approaches

Community Clinical Linkages



Funding Opportunity Announcement (FOA)

- Purpose
- Two applications
- Outcomes
- Evaluation Logic Models



Purpose

 The FOA supports statewide implementation of cross-cutting approaches to promote health and prevent and control chronic diseases and their risk factors across the lifespan.

Collectively, the 4 categorical programs
 represent activities and intervention strategies
 that draw from each of the 4 CDC domains.



Two Applications

Basic

- Non-competitive
- All 50 states and DC will be funded
- Funding formula based on population
- MT maximum \$504,325



Two Applications

Enhanced

- Competitive
- Builds on and extend activities supported with basic funding to achieve even greater reach and impact
- All states eligible to apply
- Up to 25 states will be funded
- Funding formula based on population
- MT range \$1,000,000 \$1,500,000



Outcomes

- Short-term outcomes:
 - 1. Increased state, community, worksite, school, and early care and education (ECE) environments that promote and reinforce healthful behaviors and practices across the life span related to diabetes, cardiovascular health, physical activity and healthful foods and beverages, obesity and breastfeeding.



Outcomes

2. Improved quality, effective delivery and use of clinical and other preventive services to address prevention and management of hypertension and diabetes.

3. Increased community clinical linkages to support prevention, self-management and control of diabetes, hypertension and obesity.



Outcomes

- Long-term outcomes:
 - 1. Improved prevention and control of hypertension.
 - 2. Improved prevention and control of diabetes.
 - Improved prevention and control of overweight and obesity.



Figure 1. Montana, Basic Logic Model

INPUTS	Funding	Guidance from DDT, DHDSP, DNPAO, DPH	Cardiovascular Health Program	Diabetes Prevention and Control Program	Nutrition and Physical Activity Program
BASIC ACTIVITIES	technical a: nation for sch recess standa Revise Hea	ofessional development and ssistance to schools on: and and state dietary standard hools (strategy 1, domain 2) and physical education ards (strategy 2, domain 2) Ith Enhancement content for the of Montana (strategy 2)	and diabetes away population: Medicaid ar (strategy 5 & Fort Peck Re domain 4) Provide technica	o promote hypertension areness in the following and Medicare recipients & 6, domain 4) eservation (strategy 5, I assistance and support ganization implementing	Worksites: Recruit worksites to develor each of the following stand • nutrition standards at and work functions (standards) • physical activity stand worksites (strategy 3, Promote lifestyle intervent worksites to people at high

lop and adopt dards:

- at the worksite strategy 1,
- dards in domain 2) ntion through th risk for type 2 diabetes (strategy 6, domain 4)

Healthcare:

Key Partner Organizations identified in work plan

> Provide technical assistance to healthcare facilities for quality improvement interventions and use of clinical decision support systems (strategy 4 & 5, domain 3)

Provide primary care facilities with quarterly clinic-specific feedback on diabetes care quality measures and technical assistance for quality improvement (strategy 4, domain 3)

Educate healthcare professionals on prediabetes and value of lifestyle interventions for high risk adults (strategy 6, domain 4)

Provide self-study and peer mentoring programs to healthcare professionals on diabetes education (strategy 7, domain 3)

BASIC ACCOMPLISHMENTS

Early Care and Education:

(strategy 3, domain 2)

Promote training and education on

physical activity standards for ECE staff

- ↑ adoption of healthy food service guidelines/nutrition standards
- ↑ adoption of PE/PA in schools
- ↑ adoption of PA in ECE
- ↑ reporting of blood pressure and A1c measures; and increased initiation of activities that promote clinical innovations and self-monitoring of blood pressure
- ↑ awareness of high blood pressure among patients
- ↑ awareness of pre-diabetes among people at high risk for type 2 diabetes
- ↑ participation in DSME programs (officially recognized, accredited and/or licensed)

SHORT-TERM OUTCOMES

DSME programs (strategy 7, domain 4)

↑ environments that promote and reinforce healthful behaviors and practices across the life span related to diabetes, cardiovascular health, student health, physical activity and healthful foods and beverages, and obesity

Improved quality, effective delivery and use of clinical and other preventive services to address prevention and management of hypertension and diabetes

↑ community clinical linkages to support prevention, selfmanagement and control of diabetes, hypertension & obesity

INTERMEDIATE OUTCOMES

↑ consumption of nutritious food and beverages and increased physical activity across the life span

↑ use of diabetes selfmanagement & primary prevention programs

↑ self-monitoring of high blood pressure tied to clinical support

Improved medication adherence for adults with high blood pressure and adults with diabetes

LONG-TERM OUTCOMES

Improved prevention and control of hypertension

Improved prevention and control of overweight and obesity

Improved prevention & control of diabetes

INPUTS	DHDSP, DNPAO, DPH Health Progr		Cardiovascular Health Program	772	Nutrition and Physical Activity Program	Key Partner Organizations identified in work plan	BASIC ACTIVITIES
NHANCED			grams on:	Community: Promote Montana Farmers' accepting EBT SNAP benefits assistance (domain 2, strate) Promote community level po	& provide needed technic gy 1)	Montana birthing hospita assistance for implement	

Provide School Wellness In Action grants to: improve nutrition policies and practices or apply

- for Healthier US Schools Challenge (domain 2, strategy 3)
- implement CSPAP, daily PE, or apply for Healthier US Schools Challenge (domain 2, strategy 6)

Revise Health Enhancement content standards for Montana, including comprehensive physical activity (domain 2, stratom 6)

Develop & provide training to school nurses on managing students with chronic conditions (domain 4, strategy 5)

technical assistance as needed (domain 2, strategy 4)

Create community support networks with WIC, other health professionals, and worksites in communities with Baby Friendly seeking hospitals (domain 2, strategy 7)

Promote referrals to DSME for low income women & Medicaid recipients with DM or gestational DM (domain 4, strategy 1)

Maintain support and sustainability of current Montana CVDDPP sites (domain 4, strategy 2)

In plement CHR blood pressure management on servations and TUPD statewide (domain 4, strategy 3) support systems to improve hypertension and diabetes care (domain 3, strategy 1)

Enhance & promote Montana Patient-Centered Medical Home Initiative, Provide technical assistance to engaged primary care facilities (domain 3, strategy 2)

Early Care and Education:

Contribute to fall 2013 revision of Montana Early Care Guidelines to ensure addition of physical activity & nutrition standards (domain 2, strategy 5)

ENHANCED ACCOMPLISHMENTS

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LONG-TERM OUTCOMES

Improved prevention and control of hypertension

Improved prevention and control of overweight and obesity

Improved prevention & control of diabetes

18

School-related

- Implement policies, processes, and protocols in schools to meet the management and care needs of students with chronic conditions
 - Asthma
 - Food allergies
 - Diabetes
 - Other chronic conditions related to activity, diet and weight

School-related Interventions

- Identity and track students with chronic conditions that may require daily or emergency management (asthma, food allergies)
- Develop protocols for insurance enrollment
- Assessment, counseling and referrals



- Develop and provide training to school nurses on managing students with chronic conditions
 - Work to be "housed" under the MACP
 - Coordinated by MACP Health Educator
 - Website Development
 - Planning currently underway



- Website Discussion
 - Chronic conditions
 - Online professional development
 - 504 Plan
 - Possible other items



Asthma Program Updates

- 1. Travel Vouchers
- 2. MAP Funding
- 3. Year 5 funding
- 4. Next Year's Big Sky Pulmonary Conference
- 5. Staffing
- 6. Projects
- Next MAAG meeting August 22nd in Helena



Thank you! Questions?

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